[MMCAP PARTICIPATING FACILITY LETTERHEAD]
[ADDRESS]
[CITY, STATE, ZIP]
[PHONE NUMBER]

[DATE]

FAX to 484-367-7815
Email to customerservice@adaptpharma.com

Adapt Pharma Inc – Specialty Pharm Srvc
ATTN: Customer Service
15 Ingram Blvd.
LaVergne, TN 37086

I, [PHYSICIAN, PHYSICIAN ASSISTANT OR NURSE PRACTITIONER NAME], am the responsible person for purchases made by [FACILITY NAME AND ADDRESS / IF MULTIPLE: PLEASE LIST ALL NAMES AND ADDRESSES] under my state license number [INDICATE STATE LICENSE #]) issued by the State of [INDICATE STATE NAME]

I will notify Adapt Pharma– Specialty Pharm Srvc immediately if my responsibility status and/or relationship with this facility is changed or terminated.

[PHYSICIAN'S SIGNATURE]